# Correspondence

TO THE EDITOR, *British Journal of Venereal Diseases*

**Inefficacy of cimetidine in condylomata acuminata**

Sir,

Condylomata acuminata form one of the most frustrating ailments to manage. Clinical and in-vitro observations suggest that a refractory course of condylomata may be a reflection of an underlying state of cellular immunosuppression.[1] Recently, cimetidine has been shown to possess immunomodulatory properties; its mode of action is probably related to the inactivation of suppressor cells.[2] In two experimental models[3,4] cimetidine has been highly effective in reducing the number of metastatic deposits and in increasing the life-span of tumour-bearing animals. Since cimetidine was not directly cytotoxic to tumour cells in vitro, its activity could be ascribed to the augmentative effect on the immune response.[4] On the basis of these data we studied the efficacy of cimetidine as an adjuvant in treating chronic condylomata acuminata.

Twelve healthy patients aged 19-39 years (11 men and one woman) entered the study. All had multiple venereal warts of 4-60 months' duration, and all had been unsuccessfully treated before. Local treatment consisted of podophyllin 10-20% in collodion once weekly until all lesions had resolved. Cimetidine 400 mg was given four times daily for eight weeks. Two patients refused further treatment after four weeks because of exacerbation during treatment. Ten patients completed their treatment course, of whom eight had persistent condylomata at the end of the trial period and after 1-3 months' follow up. One patient defaulted, but inquiry by telephone indicated that all the lesions had completely resolved. In only one case could a complete cure be claimed. This patient had frenal lesions only. Side effects were not found. Interestingly, three patients had concomitant common warts on the hands or feet, none of which showed any improvement during treatment with cimetidine.

These findings show that cimetidine has a negligible effect on venereal warts. Thus, a randomised prospective study in this field seems unwarranted.

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TO THE EDITOR, *British Journal of Venereal Diseases*

**Post-gonococcal cervicitis and post-gonococcal urethritis**

Sir,

We were interested to read of the high incidence of post-gonococcal urethritis and cervicitis in a recent article.[1] We rarely see such conditions in this clinic nowadays.

Because of the reported high rate of coincidental infection with chlamydia, we give all patients with gonorrhoea (male and female) a 10-day course of oxytetracycline (500 mg twice daily). This course is the same as we use for non-specific urethritis (NSU) and contacts of non-specific urethritis, and is given after ampicillin 2 g and probenecid 1 g in one immediate oral dose. We have never regretted giving oxytetracycline in these cases. Such a regimen is associated with a low incidence of post-gonococcal syndromes (3%), low treatment failure rates for gonorrhoea (<1%), and therefore less necessity for long-term follow up. One disadvantage may be that an increased number of women develop candidosis but this is usually diagnosed and treated before the final follow-up visit.

This management may not meet strictly academic ideas of "diagnosis before treatment," but in the absence of chlamydial cultures there seems no practical acceptable alternative (compare NSU and NSU contacts). Even if only a small percentage of men and women treated for gonorrhoea avoid chlamydial epididymitis or salpingitis by this means, it is surely worthwhile. In addition, it decreases the likelihood of partners reinfecting each other with chlamydia.

Yours faithfully,

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TO THE EDITOR, *British Journal of Venereal Diseases*

**Aetiology and management of non-specific vaginitis**

Sir,

Dr Dattani and his colleagues[1] are to be congratulated in attempting to tackle the complex clinical and microbiological features of the ubiquitous and distressing non-specific vaginitis. They do, however, seem to be basing their assumption, that most cases of *Gardnerella vaginalis* vaginitis are cured spontaneously, on the 10 cases in their treatment control group who regressed without treatment. I would suggest that this is a little premature. Our experience of *G vaginalis* vaginitis in Sheffield over five years (and 5000 patients) suggests that certainly some cases cured themselves, but this is by no means the rule.

Yours faithfully,

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TO THE EDITOR, *British Journal of Venereal Diseases*

**False-negative reagin test results to non-agglutinating (incomplete) antibodies**

Sir,

We wish to report two cases of clinically active syphilis in which the results of the rapid plasma reagin (RPR) test for measuring antibodies to cardiolipin were negative and the *Treponema pallidum* indirect haemagglutination assay (TPHA) and fluorescent treponemal antibody (FTA) tests were positive. The FTA test result was